



DHSS Public Health/Medical Professionals Volunteer Information Sheet

Name: _____

(Last)

(First)

(MI)

Are you employed by: (Check One:) DHSS LPHA Medical Profession Other

Profession (Select One):

Volunteer Type (Check One): Individual Company/Organization

Address: _____

City: _____ State: _____ ZipCode: _____

Contact Information:

Work Phone #: _____

Home Phone #: _____

Pager #: _____

Cell #: _____

Email Address: _____

Emergency Contact Name: _____

Emergency Contact Phone #: _____

Supervisor's Name: _____

Supervisor's Phone Number: _____

How soon can you activate? (Check One):

Less than 24 hours 24-48 hours 2-5 days 1 week

Available Where? (Check One):

Outstate Instate Both

Time can be away from home (Check One):

1 week 2 weeks 3 weeks

Currently employed in your profession? (Check One): Yes No

If yes, where employed? _____

Specialty: (Ex. Pediatrics, Geriatrics) _____

Certification: _____

Primary Clinical Practice Area: _____

Any special skills or considerations (have Emergency Response Training, Bi-Lingual, Multi-Lingual, etc.):

Return to DHSS Center for Emergency Response and Terrorism at:

Fax: (573) 526-8389

E-Mail: hurricanevolunteer@dhss.mo.gov

Mail: PO Box 570

Jefferson City, MO 65102-0570